State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • People with Intellectual and Developmental Disabilities

Provider Certification Application

Applicant

Business name _____

Administrator _____

Current provider numbers _____

Physical address/City/Zip _____

Mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Table of Services *Check box for each service the provider plans to offer to participants. (NA indicates services unavailable for the waiver specified in that column.)*

Waiver service	APDD	ALI	CCMC	IDD
Nursing oversight and care management	NA	NA		
Care coordination				
Chore				
Adult day			NA	NA
Residential supported living			NA	NA
Day habilitation		NA		
Residential habilitation	////	////	////	////
Family home habilitation		NA		
Supported-living habilitation		NA		
Group-home habilitation		NA		
In-home support habilitation		NA		
Supported-employment		NA		
Intensive active treatment		NA		
Respite care				
Family-directed respite care	NA	NA		
Transportation				
Meal	////	////	////	////
Congregate meals				
Home-delivered meals				
Environmental modification				

Geographical area to be served *Check box for each location at which services will be offered.*

- ☐ Anchorage
- ☐ Interior
- ☐ Northwest
- ☐ Southcentral
- ☐ Southeast
- ☐ Southwest
- ☐ Statewide

Business information

Location of participant records: _____

Form of organization
- ☐ Sole proprietorship
- ☐ General partnership
- ☐ Limited liability company
- ☐ For-profit corporation
- ☐ Non-profit corporation
- ☐ Limited partnership
- ☐ Government/public agency
- ☐ Tribal health organization

EIN/Tax ID number _____

Billing agent ☐ Agency employee ☐ Contractor

Name of billing agent _____

"Pay-to" name (business or individual) _____

"Pay-to" address _____

Required attachments *Review the SDS certification website for instructions and content requirements.*

For each waiver service checked on the *Table of Services,* submit the following:

- *Provider Certification Application Service Declaration* for that service
- Attachments required on the *Service Declaration*

Providers that will operate without employees must submit the following form:

- *Provider Certification Application Worker Assurances*

Note: Send only one copy of the following attachments if the provider offers multiple services:

- State of Alaska business license;
- Certificate of Insurance;
- Organization chart
- Personnel list
- *Notice of Appointment: Program Administrator* form, if that program administer will be appointed to manage more than one waiver service
- Operations manual
- Core employee policies

Provider assurances

I affirm to that the provider will comply with the Medicaid Home and Community-Based Waiver Services regulations, including the Provider Conditions of Participation; 7 AAC 130.200 – 7AAC 130.319; and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for recertification is true, accurate, and complete.

Owner/Administrator/Director

_____ _____

Signature *Print name*

Title _____ Date _____

Name of person completing this application _____

Telephone/cell number _____ Email _____